DOCUMENT RESUME

ED 166 608 CG 013 218

AUTHOR Harder, David W.; And Others
TITLE Self-Derogation and Psychopathology.
SPONS AGENCY National Inst. of Mental Health (DHEW), Rockville, Md.
PUB DATE 29 Aug 78
GRANT NIMH-MH-25466
NOTE 10p.

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Anxiety; *Behavior Patterns; *Mental Health Programs; Patients (Persons); *Prognostic Tests; *Psychopathology; Psychosis; Psychotherapy; *Self Esteem; *Therapy
IDENTIFIERS *Strauss Carpenter Prognostic Scale

ABSTRACT

Self-derogation relates significantly to the severity of psychopathology regardless of how it is measured. This study examined 152 patients and ex-patients from two community mental health catchment areas two years after their first admission, as well as 97 outpatients beginning therapy. Included were indices of diagnostic severity; overall health/sickness; psychotic, neurotic, affective, schizophrenic or suicidal symptomatology; and reported distress. Neurotic and affective symptomatology and overall health/sickness were most highly related to self-derogation. These findings point to the need to recognize and treat low self-esteem in psychopathological states other than depression. Self-derogation may prove to be a prognostic marker for these patients, since it relates to social and employment functioning as well as to symptom intensity. (BN)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Presented at the American Psychological Association 86th Annual Convention, Toronto, August 29, 1978.

ED166608

SELF-DEROGATION AND PSYCHOPATHOLOGY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

D W Harder

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

David W. Harder, Ph.D.
John S. Strauss, M.D.
Ronald F. Kokes, Ph.D.
Barry A. Ritzler, Ph.D.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Abstract

To test an hypothesized relationship between the self-derogation component of low self-esteem and all forms of psychopathology, including non-depressive disorders, the present study examined these relationships in two samples of subjects. The first were 152 patients and expatients from two community mental health catchment areas followed up two years after their first functional-disorder psychiatric admission. The second group were 97 outpatients from the same catchment areas beginning therapy at a CMHC. Within each sample self-derogation was related significantly to severity of diagnosis, overall health-sickness, numerous indices of symptomatology severity and a measure of difficulty in social/employment functioning. These findings point to the need to recognize and treat self-derogation in psychopathological states other than depression. In addition, they raise the important question of direction of causality between self-derogation and observed psychopathology.

CG013218

SELF-DEROGATION AND PSYCHOPATHOLOGY[1]

David W. Harder, Ph.D., John S. Strauss, M.D., Ronald F. Kokes, Ph.D., and Barry A. Ritzler, Ph.D.

Previous research (Rosenberg, 1965; Kaplan & Pokorny,1969) has demonstrated that among adolescents and in the general population, high self-derogation, one component of poor self-esteem, is associated with anxiety, psychophysiological symptoms, and depression. For the general population self-derogation is also related to the use of psychiatric facilities. A different large sample study (Kaplan, 1975,1977) of adolescents has linked increasing self-derogation with the onset of possibly psychopathological conditions by providing longitudinal evidence that self-derogatory attitudes increase prior to the performance of a wide range of deviant behaviors. The role of self-derogation in clinically diagnosed depressive disorders, whether neurotic or psychotic, is usually quite obvious. However, self-derogation is not so clearly related to other types of psychopathology. Nevertheless, several psychoanalytic theorists have placed self-derogation at the core of schizophrenia. For example, R. White (1963) maintains that self-condemnation deriving from a lack of interpersonal and instrumental competence is central to schizophrenia, while Spotnitz (1976) has viewed self-hate deriving from a profound ambivalence toward love objects as central. Perhaps manic states seem the least likely psychiatric conditions to involve self-derogatory attitudes, but analytic writers, such as Jacobson (1953), who view manic states as a defense against an underlying depression do hypothesize that self-derogation is an important aspect of such disorders. Fitts (1972) has provided one of the few empirical investigations of the relationship of psychiatric problems and varying aspects of self-esteem in a large sample of psychopathological cases. His findings were that poor self-esteem seemed related to most neurotic conditions and that, furthermore, 87% of his large psychotic group showed markedly deviant self-concepts. Some of the manic and paranoid patients managed to maintain, at least sporadically, positive self-concepts. However, there were definite inconsistencies in their evaluative self-reports. Most often among this group of psychotics the self concepts were "entirely negative" (p.43). The present study sought to further the empirical investigation of the relationship between self-derogation and psychiatric disorders. The guiding hypothesis is that self-derogation in psychiatric patients is significantly related to numerous indices of psychopathological severity, including an overall measure of health-sickness, measures of symptom severity, a measure of difficulty in social and employment

[1]This research supported in part by NIMH Grant #MH25466.

functioning, and a subjective distress measure. The hypothesis tested implies the importance of considering and treating poor self-esteem in pathological states other than depression.

METHOD

Two groups of subjects participated in the study. The first was a group of 152 patients and ex-patients from an original sample of 217 functional disorder inpatients first studied two years earlier at their initial psychiatric admissions. Of the 217, 180 participated in the 2-year follow-up, from which 152 provided complete data for the analyses reported here. At the time of admission, these subjects comprised a demographically representative sample of first admissions from two community mental health catchment areas (Strauss, et al, 1978). Their follow-up status, as expected, reflected a broad range of psychopathology, from cases with a deteriorating course to currently asymptomatic ex-patients. The second group of subjects were 97 randomly selected psychiatric outpatients from the same two catchment areas who had never been previously hospitalized in a psychiatric facility. They participated at the time of beginning treatment in a Community Mental Health Center clinic.

All subjects were interviewed by experienced clinicians with a series of interview schedules adapted closely from reliable standardized procedures used in the WHO International Pilot Study of Schizophrenia (WHO, 1973). These included the Psychiatric Assessment Interview (PAI), Psychiatric History and Social Data Interview. In addition to the symptom, psychiatric history, social and demographic data yielded by these forms, ratings were made by the clinical interviewers on those items of the Strauss-Carpenter Prognostic Scale (Strauss and Carpenter, 1974) assessing level of social and employment functioning during the past year. A rating was also made on the Menninger Health-Sickness scale (Luborsky, 1962). A DSM-II diagnosis was assigned to each patient by the clinical researcher after the intensive interviews and following a review of the patient's chart. Self-derogation was measured by the Kaplan-Pokorny Scale (1969), also administered during the interviews.

The DSM-II diagnoses were grouped into five categories to represent points on a continuum proceeding from the least to the most pathological. The post-first admission group included 58 asymptomatic or situational-disorder patients, 20 neuroses, 45 personality disorders, 3 affective (manic) psychoses, and 26 schizophrenic and other psychoses. The outpatient group included 22 asymptomatic or situational-disorder patients, 37 neuroses, 32 personality disorders, 0 affective disorders, and 6 schizophrenic and other psychoses. Eight other continuous pathology measures were defined for the study. These included the

Menninger Health-Sickness variable, a measure of subjective distress (from the PAI), and dimensional measures of the severity of psychotic, neurotic, affective, schizophrenic and suicidal symptomatology in the month prior to the research interview which were computed from the detailed information gathered in the PAI. In addition, the four Strauss-Carpenter items were averaged to provide an overall measure of social and employment functioning.

RESULTS

The first step taken in data analysis was to examine the relationship between DSM-II diagnostic classification and self-derogation by means of one-way analysis of variance. One ANOVA was run for each of the patient samples. In each case, there was a significant relationship between self-derogation and diagnostic classification (see Table 1). The mean scores of the groups increased from the least pathological category to the most pathological, as predicted by the hypothesis, for the outpatient sample only. The ordering of group means for the followed-up inpatient sample was somewhat different. The three affective (manic) patients showed very low self-derogation, followed by the asymptomatic and situational disorders, the schizophrenic and other psychoses, and finally the neuroses and personality disorders. The manic patients are perhaps showing the kind of defensive self-esteem inflation described by theorists like Jacobson. The second departure from prediction is the mean of the psychotics, which is lower than the neuroses and personality disorders in this follow-up inpatient group, and is about equal with the level of self-derogation shown by the asymptomatic and situational disorders in the outpatient group.

Despite obvious departures from the expected relationship for some past inpatients, there was still a possibility that across the entire sample, self-derogation does relate to indices of psychopathology severity. The second step in the analysis was the calculation of Pearson product-moment correlations between self-derogation and all ten of the continuous pathology measures for each sample. These correlations are presented in Table 2. Almost all of them are statistically significant at the .05 level. The exceptions are the degree of reported distress for outpatients and the degree of psychotic symptomatology and schizophrenic symptomatology for the followed-up inpatients.

A third step in the analysis was to control for other factors which might mediate a significant relationship between self-derogation and psychopathology in such a way as to obscure it in the bivariate analyses. This was accomplished by including variables of age, sex, social class, and social supports (incorporating marital status) along with self-derogation as the independent variables in a series of multiple regressions. One regression was run for each continuous

index of psychopathology in each sample. Regressions were stepwise with an F-value inclusion criteria of 3.94, sufficient to include all independent variables significantly related to a dependent variable at the .05 significance level. Table 2 presents the beta weights (in parentheses) which emerged from the multiple regression analyses between self-derogation and pathology indices. Like correlation coefficients, these values can be taken as a measure of association between variables. For the outpatient sample, most values decreased slightly due to self-derogation variance overlap with significant social supports variance, but the self-derogation betas remained significant. In addition, the insignificant self-derogation relationship with reported distress emerged as a signficant beta. For the followed-up inpatient sample, the values of association tended to increase, once race and social supports were controlled. In this sample, too, previously insignificant relationships, those with psychotic symptomatology and schizophrenic symptomatology, became significant. The association between self-derogation and level of social/employment functioning decreased for both samples because of overlap with social supports but still remained significant.

DISCUSSION

As predicted by the overall hypothesis, self-derogation relates significantly to the severity of psychopathology, however measured. The study included indices of diagnosis severity, overall health-sickness, psychotic, neurotic, affective, schizophrenic, and suicidal symptomatology, and reported distress. Neurotic symptomatology, affective symptomatology, and overall health-sickness were most highly related to self-derogation. Social/employment difficulties and psychotic and schizophrenic symptomatology were the least related. In addition, the analysis of variance revealed that a small group of manic patients and some other psychotics were exhibiting very low self-derogation. It seems likely that the psychotics most prone to a defensive inflation of self-esteem were the paranoid schizophrenics (Havener and Izard, 1962). To examine this possibility, correlations were calculated between self-derogation and three symptom dimensions assessed by the PAI that are part of paranoia-suspiciousness, delusions of reference and delusions of grandeur. None of these correlations were significant for either sample, thus suggesting the likelihood that manic and paranoid patients were decreasing the relationship between self-derogation and psychotic symptomatology. However, once factors of race and social supports were controlled, self-derogation does relate significantly to psychotic and schizophrenic pathology for both samples.

These findings point to the need to recognize and treat low self-esteem, particularly the self-condemnatory component, in psychopathological states other than depression. If indeed, the manic and paranoid patients are exhibiting defensively high self-esteem, they too might need help with difficulties in self-esteem.

An important issue in the relationship between self-derogation and degree of psychopathology is the line of causality. Are the self-derogatory attitudes relatively stable ones which determine the psychopathology, or are they rather the result of the pathological disturbance? Perhaps, too, there may be an interdependent causality such that self-derogation increases pathology and vice-versa. Because the cross-sectional nature of these data cannot answer these questions, further follow-up data, which we expect to collect from both samples, will be required to determine the stability of the self-derogatory attitudes, their role in changing levels of pathology, and the effects of changing levels of pathology upon changing levels of self-derogation.

One final note: Self-derogation may prove to be a prognostic marker for future outcome in these patients, since it relates to social and employment functioning as well as to symptom intensity. This possibility will also be checked in the further follow-ups now underway.

TABLE 1

ANALYSES OF VARIANCE OF SELF-DEROGATION

BY DIAGNOSTIC GROUPS

Outpatient Sample (N=97)

Diagnostic Group	N	Mean Self-Derogation
Asymptomatics/Situational Disorders	22	12.23
Neurotics	37	15.57
Personality Disorders	32	17.44
Schizophrenic and Other Psychoses	6	20.50

$F=2.77$, $df=3, 93$, $p<.05$

Followed-up Inpatient Sample (N=152)

Diagnostic Group	N	Mean Self-Derogation
Asymptomatics/Situational Disorders	58	9.89
Neurotics	20	16.45
Personality Disorders	45	15.09
Affective Disorders	3	4.00
Schizophrenic and Other Psychoses	26	12.00

$F=9.02$, $df=4,147$, $p<.001$

TABLE 2

PEARSON CORRELATIONS BETWEEN SELF-DEROGATION AND PATHOLOGY MEASURES

(Multiple Regression Standardized Betas in Parentheses)

Pathology Measure	Outpatient Sample (N=97)	Followed-up Inpatient Sample (N=152)
Continuum Diagnosis	.366 (.231)	.219 (.202)
Menninger Health-Sickness[a]	-.378 (-.378)	-.453 (-.302)
Psychotic Symptomatology	.268 (.228)	.147# (.232)
Neurotic Symptomatology	.489 (.466)	.575 (.570)
Affective Symptomatology	.438 (.438)	.445 (.529)
Schizophrenic Symptomatology	.354 (.314)	.089# (.199)
Suicidal Behavior	.266 (.266)	.365 (.375)
Reported Distress	.188# (.212)	.228 (.323)
Social/Employment Difficulty	.229 (.194)	.272 (.191)

#Not significant at $p < .05$ level. Rest of correlations and betas are significant.

[a]High scores on this variable reflect absence of pathology. On all other variables listed here high scores reflect pathology.

References

Fitts, W.H. The Self Concept and Psychopathology. Nashville, Tennessee: The Dede Wallace Center, 1972.

Havener, P.H., and Izard, C.E. Unrealistic self-enhancement in paranoid schizophrenias. J. Consult. Psychol., 26:65-68, 1962.

Jacobson, E. Contribution to the metapsychology of cyclothymic depression. In P. Greenacre (ed.), Affective Disorders. New York: International Universities Press, 1953, pp. 49-83.

Kaplan, H.B. Increase in self-rejection as an antecedent of deviant responses. J. Youth Adol., 4:281-292, 1975.

Kaplan, H.B. Increase in self-rejection and continuing/discontinued deviant response. J. Youth Adol., 6:77-87, 1977.

Kaplan, H.B., and Pokorny, A.D. Self-derogation and psychosocial adjustment. J. Nerv. Ment. Dis., 149:421-434, 1969.

Luborsky, L. Clinicians' judgments of mental health. Arch. Gen. Psychiat., 14:407-417, 1962.

Rosenberg, M. Society and the Adolescent Self-Image. Princeton, N.J.: Princeton University Press, 1965.

Spotnitz, H. Psychotherapy of Preoedipal Conditions. New York: Jason Aronson, 1976, pp. 93-163.

Strauss, J.S. and Carpenter, W.T. Prediction of outcome in schizophrenia: II. Relationships between predictor and outcome variables. Arch. Gen. Psychiat., 31:37-42, 1974.

Strauss, J.S.; Kokes, R.F.; Ritzler, B.A.; Harder, D.W. and VanOrd, A. Crucial patterns of psychiatric disorder. Submitted for publication, 1978.

White, R. Ego and reality in psychoanalytic theory: A proposal regarding independent ego energies. Psychological Issues Monographs, no. 11 (whole). NY: International Universities Press, 1963.

World Health Organization: The International Pilot Study of Schizophrenia, Vol. 1. Geneva: World Health Organization, 1973.